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ABSTRACT

This report summarizes a 3-year review of reports of child abuse and neglect in New York State's mental hygiene facilities. The study determined that greater efforts are required to ensure protection of those children who were "repeat" alleged victims and who, as a group, were involved in 400 of the 850 reports to the State Central Register. The report also identified unstructured activity times on residential units, limited presence of clinical staff, and the use of physical interventions and restraints as the major risk factors leading to child abuse and neglect allegations. In over two-thirds of the reports, there was no reported physical injury, and an additional 25 percent required only first aid. Adult to child sexual abuse was alleged in 15 percent of the reports, and supervision neglect resulting in child to child sexual activity was alleged in 14 percent. Twenty-four percent of the reports from 143 facilities across the state were sustained as child abuse or neglect upon investigation. Figures and text detail the findings. Recommendations address confusion over reporting, underreporting in some programs, prevention for "high risk" children, high risk behaviors and circumstances, and accountability. Appendices present statutory definitions, reporting rates, and agency responses to the report. (DB)

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Child Abuse and Neglect in New York State Office of Mental Health and Office of Mental Retardation and Developmental Disabilities Residential Programs

A Review of Reports Filed
October 1, 1986 - September 30, 1989

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Child Abuse and Neglect in New York State Office of Mental Health and Office of Mental Retardation and Developmental Disabilities Residential Programs

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NYS Commission on Quality of Care
for the Mentally Disabled

February 1992

Preface

With the passage of the Child Abuse Prevention Act of 1985, the Commission assumed primary responsibility for investigating child abuse and neglect allegations in residential programs operated or licensed by the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities. Since October 1986 when this statute, commonly known as CAPA, became effective, over 1,200 allegations of child abuse and neglect in these settings have been reported to the Commission and investigated.

As a result of these activities, the Commission has spent considerable time inside state-operated children's psychiatric centers and units, state-licensed residential treatment facilities for children, community-based intermediate care facilities serving children with developmental disabilities, children's psychiatric units of general and private psychiatric hospitals, and state-operated developmental centers. In total, the Commission has investigated reports in over 143 different residential programs serving children with mental disabilities across New York State.

These investigations have helped the Commission gain a better understanding of the incidence of child abuse and neglect, of the children most at risk, and of these residential programs themselves. This report summarizes data from the 850 cases investigated by the Commission in the first three years of CAPA and discusses some of the things the Commission has learned over the past five years.

At the outset, it is important to note that while the terms "child abuse and neglect" conjure up images of battered children, sadistic abuse, or gross neglect of basic needs, the types of allegations made regarding children in residential mental hygiene facilities were of a markedly different nature.

- In approximately two-thirds of the reports, there was no reported physical injury to the alleged victim.
- In another 25% of the cases, the reported injury required first aid.
- The vast majority of allegations of neglect dealt with breakdowns in supervision of children which permitted them to engage in harmful activity or placed them at risk of harm.

Significantly, upon investigation, most of the cases were "unfounded" either because the incident could not be substantiated, or because, although the incident occurred, it did not meet the statutory definition of child abuse or neglect. Yet, the investigation of the allegations made has prompted the Commission to identify preventive measures to avoid circumstances that may place these and other children at risk of harm. At the same time, it has spurred the Commission to devote greater attention to the conditions of care affecting all children in such residential mental hygiene facilities. For example, the Commission has:

- reviewed the use of restraint and seclusion and PRN medications in the children's psychiatric unit of a general hospital. This review included several follow-up visits to ensure that corrective actions continued to be effectively maintained. A similar review of restraint and seclusion procedures at a private psychiatric hospital also resulted in similar systemic reforms in these practices;

- reviewed selected care and treatment issues regarding 121 children in 30 different facilities, closing each case with a letter of findings to the facility;
- visited and reviewed basic care and treatment and quality of life issues in the children's or adolescents' units of four hospitals run by the Health and Hospitals Corporation (NYC);
- reviewed the operation of the children's unit at a state-operated psychiatric center, resulting in closing admissions, an internal OMH review, and finally its redesign under new leadership;
- completed a review of the functioning of the incident reporting, investigation and review procedures in another children's psychiatric center;
- published a report, *Supervision and Care of Seriously Mentally Ill Children: A Case Study*, describing the inadequate supervision of children at a residential treatment facility which contributed to the homicide of one of the residents and the imprisonment of another.

In this report, the Commission presents statistical data of the experience under the first three years of CAPA, as well as observations on the systemic issues which emerged from an analysis of the data. Among the significant observations are the following:

- Boys over 13 years of age who were non-white and residing in mental health programs were the most common alleged victims.
- Almost half of the filed reports (45%) involved a "repeat" alleged victim, a child who had been cited in one or more additional reports of institutional abuse or neglect over the three-year period studied.
- Behavior management issues played a central role in many of the reports filed. Nearly one-fourth of the reports (22%) alleged inappropriate restraint or seclusion of children in behavioral incidents. Furthermore, the circumstances of many of the reports alleging physical abuse (55% of the reports) also related incidents where staff were trying to control oppositional or dangerous behaviors of children.
- Too much unstructured time in the late afternoons and early evenings, as well as the absence of clinical staff from the living units during these times, appeared to increase the risk of behavioral incidents. Of note, less than 5% of the reports allegedly took place in a structured program area (e.g., school, gym, treatment or music/art room), and one-third of the reports (34%), according to staff accounts, took place during "free time."
- Almost one-third of the reports (29%) referenced allegations of adult-to-child sexual abuse (15%) or supervision neglect resulting in child-to-child sexual activity (14%), providing vivid reminders of the high incidence of sexual abuse among many of the children prior to their placement in residential programs, as well as the significant difficulties in protecting these children in large congregate settings.

The time spent in many of these residential facilities also brought home the extent to which children living in these settings are deprived of many of the normal activities of childhood -- like being a part of a neighborhood, attending a regular school, having a bicycle, being a scout, playing an intramural or interscholastic sport, or joining the school band or drama club. For all of the children we studied, this placement also totally restricted their ability to know and play with non-handicapped peers for extended periods of time.

For children who typically came from troubled and unstable families, residential facilities often offered shift staff, high staff turnover, and limited contact with primary therapists who did not work past five o'clock or on weekends, most of the hours that the child was in the residential program and not attending the campus school.

Behavior management of groups of children with emotional problems often boiled down to "level systems" which, despite protestations to the contrary, offered far more punishments than rewards and, when these failed, used physical interventions, mechanical restraints, seclusion, or time-out. Although all residential programs the Commission has visited have written individualized treatment plans, when the children are asked about their treatment programs, they invariably describe the rules, infractions, and rewards and punishment of group level systems.

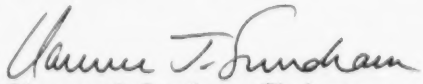
During investigation of CAPA cases, the Commission has also seen some children's facilities at their worst. At two state mental health facilities where substantial problems in the supervision, care, and treatment of children led to the widespread allegations of abuse and neglect of children, the Office of Mental Health closed the programs for admissions for months and replaced most senior administrative and clinical staff. At another licensed program, long-term neglectful supervision of adolescents contributed to the circumstances which led to the homicide of a young girl.

It would be misleading to suggest that such serious problems plague most children's facilities. At most of the facilities visited, Commission staff have observed many caring and kind staff doing their best, within the inherent limitations of an institutional setting, to nurture and treat the youngsters in their custody. Yet, even with these invaluable assets, congregate settings are often unable to adequately supervise the children and, more importantly, they cannot provide what many of these children most need — nurturance and parenting by a family that cares for them.

This report closes with a number of important recommendations designed to add to the safety net for children with mental disabilities living in congregate residential treatment facilities. The Commission realizes that, despite their inherent limitations, congregate treatment facilities currently remain an important component of the state's care system for children and must be made as safe and nurturing as possible.

The Commission supports and applauds the policy direction of reducing reliance upon institutional settings for the care and treatment of children with mental disabilities. We strongly support the expansion of the family-based treatment programs of the Office of Mental Health and the variety of family support, family care and care at home programs developed by OMRDD. It is our hope that, in this Decade of the Child, all children will have a realistic opportunity to grow up and have their needs met in their own families or, where that is not possible, in another family setting.

This reports represents the unanimous opinion of the members of the Commission. A draft of this report was shared with the State Office of Mental Health and the State Office of Mental Retardation and Developmental Disabilities. Their responses are appended to the report.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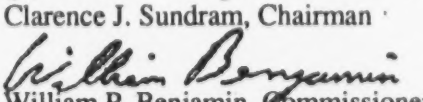
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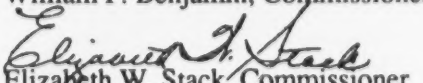
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Introduction

In accord with the Child Abuse Prevention Act (CAPA) of 1985, on October 1, 1986 the Commission assumed new responsibilities for the primary investigation of child abuse and neglect allegations occurring in residential programs operated or licensed by the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities.

In accord with the provisions of the Child Abuse Prevention Act (CAPA) of 1985, on October 1, 1986 the Commission assumed new responsibilities for the primary investigation of child abuse and neglect allegations occurring in residential programs operated or licensed by the Office of Mental Health (OMH) and the Office of Mental Retardation and Developmental Disabilities (OMRDD). The CAPA legislation charged the Commission with taking immediate interventions in response to reports of these allegations to ensure the safety of the child(ren), investigating the circumstances of the report, and making a recommendation for a final determination to the NYS Department of Social Services (DSS). DSS is then responsible for issuing the final determination of "indicated" or "unfounded" of the report, based on its review of the Commission's recommendation. In "indicated" reports, the Commission is also responsible for making needed recommendations for corrective actions to the director of the reporting facility, who is then required to submit a corrective action plan in response to these recommendations.

The CAPA legislation also required the NYS Department of Social Services to assume similar new responsibilities for the primary investigations of reports of institutional child abuse or neglect emanating from other children's residential programs (e.g., residential schools, residential care facilities for children, programs for delinquent youth, etc.).

What Is Institutional Child Abuse and Neglect?

Other important provisions of the CAPA legislation provided the first New York statutory definitions of institutional child abuse and neglect. The new statutory definitions of *institutional abuse* are essentially the same as the state's statutory definitions for abuse in familial, foster care, or day care settings, while the definitions for *institutional neglect* were modified substantially.[1]

Important provisions of the CAPA legislation provided the first New York statutory definitions of institutional child abuse and neglect.

In accord with the CAPA definitions of institutional abuse and neglect, "indicated" reports of physical abuse and, to a lesser degree, neglect are predicated on a high threshold of actual or potential injury or impairment to the child(ren), while the definition of sexual abuse is tied to the existing penal code. Specifically:

- acts of alleged physical abuse must result in physical injury *which causes or creates a substantial risk of death, serious protracted disfigurement, protracted impairment of physical or emotional health or protracted loss or impairment of the function of any organ*;
- acts of alleged sexual abuse must involve a custodian committing or allowing to be committed *a sexual offense against a child as described in the penal law* or allowing, permitting or encouraging a child *to engage in various sexual acts described in the penal law*;
- acts of alleged neglect *must impair or place in imminent danger of becoming impaired, the child's physical, mental or emotional condition* by administering drugs contrary to a physician's prescription or by failing to adhere to accepted standards of custodial care, education, medical care, supervision, and the use of restraints and seclusion.

Additionally, according to CAPA definitions, the actual or substantial risk of injury, harm, or impairment to the child must be attributable to "other than accidental means" and to a specific custodian or custodians (e.g., director, operator, employee or volunteer). The law also defines the standard of proof in these cases as "some credible evidence."

[1] The CAPA definitions of institutional child abuse and neglect, as well as New York's statutory definitions of child abuse and neglect in familial, foster care or day care settings, are listed in Appendix A

It is important to note that although the CAPA legislation assured new statutory definitions for institutional child abuse and neglect, there remains considerable confusion in the field as to what actually constitutes institutional child abuse and neglect. Part of this confusion emanates from the relative recency of the legislation, but it more substantially derives from the significant differences between the new CAPA definitions of abuse and neglect and the pre-existing and continuing definitions of abuse and neglect in the separate state regulations of both the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities, which are subject to a separate reporting and investigation process.

It is important to note that although the CAPA legislation assured new statutory definitions for institutional child abuse and neglect, there remains considerable confusion in the field as to what actually constitutes institutional child abuse and neglect.

Notwithstanding the enactment of CAPA in 1985, the OMH/OMRDD regulatory definitions for abuse and neglect remain in effect for the programs they operate or license. Reprinted in Appendix B, these regulatory definitions differ significantly between the two Offices, but they share a much broader net for the types of employee actions and inactions which may constitute abusive or neglectful behavior.[2] Of special note, the regulatory definitions of both agencies *do not require* actual or substantial risk of serious physical or emotional injury or impairment or the identification of specific employee perpetrators as predicates for a "sustained" report of abuse or neglect. Additionally, unlike reports made to the State Central Register (SCR) in which every custodian found guilty of abuse or neglect is placed on the Register for 10 years beyond the 18th birthday of the youngest child named in the report, both OMH and OMRDD have more discretion in determining outcomes for employees found guilty of abuse and neglect.

Many line staff, clinicians, supervisors, and even administrators of mental health and mental retardation residential programs are confused by the apparent discrepancies in the regulatory and statutory definitions of abuse and neglect as they apply to children in their programs. Particularly problematic for these providers is the threshold of "seriousness" in custodian misconduct which translate to abuse and neglect under the CAPA statute versus OMH/OMRDD regulations. Due to these differing thresholds, the Commission is often compelled to "unfound" reports of institutional child abuse and neglect in its recommendations to the Department of Social Services, although the report would clearly have been "sustained" in accord with the OMH/OMRDD regulatory definitions. Not surprisingly, these situations have caused many unfortunate misunderstandings and conflicts as the Commission has applied the new CAPA statutory definitions.

[2] In accordance with the CAPA legislation, both OMH and OMRDD did append to their regulatory definitions of abuse and neglect CAPA's definitions of institutional child abuse and neglect. In both cases, however, the regulations are clear that these definitions augment the regulations' other definitions — they do not replace them.

Responding to Reports

In New York, reports of institutional child abuse and neglect, like other reports of child abuse and neglect in the state, are called into a central toll-free hotline (1-800-342-3720) at the State Central Register of Child Abuse and Maltreatment. If a report relates to a child residing in a residential facility operated or licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities, the hotline operator will take down the report and then immediately transmit the report to the Commission (Figure 1). To ensure capability to receive State Central Register calls at any hour of the day or night, the Commission maintains a 24-hour on-call staff system.

Once a call has been received, Commission staff promptly review the complaint and make a follow-up call to the "reporter" and the residential facility to ensure the immediate safety and protection of the alleged child victim, as well as other children in the facility, and to obtain a clear understanding of the allegation. In most cases, these calls reveal that adequate precautions are being taken to protect the child(ren), but in the rare instances where these precautions have not been taken, the Commission assures that appropriate protective actions are initiated, either through discussions with facility managers or clinicians, or through the prompt arrival of a Commission investigator on site.

Once a call has been received, Commission staff promptly review the complaint and make a follow-up call to the "reporter" and the residential facility to ensure the immediate safety and protection of the alleged child victim, as well as other children in the facility, and to obtain a clear understanding of the allegation.

For the vast majority of cases, after telephone contact has been made regarding the report, the report is discussed promptly at a case review, where the case is assigned to a Commission investigator, and a preliminary investigation plan is developed. In accord with statutory time frames, *within 90 days of the receipt of the initial report*, the investigation is completed and a report is prepared with recommendations for "indicating" or "unfounding," as well as other needed facility corrective or preventive actions.

This recommendation for "indicating" or "unfounding" is transmitted to the Department of Social Services on a DSS Form 2223. The residential program director also receives a letter communicating the Commission's recommendation to DSS and, where warranted, other recommendations for needed corrective and preventive actions. Upon its review, DSS also notifies the alleged perpetrator(s), the parents or guardians of the alleged victim, the residential program director, and the Commission of its final determination.

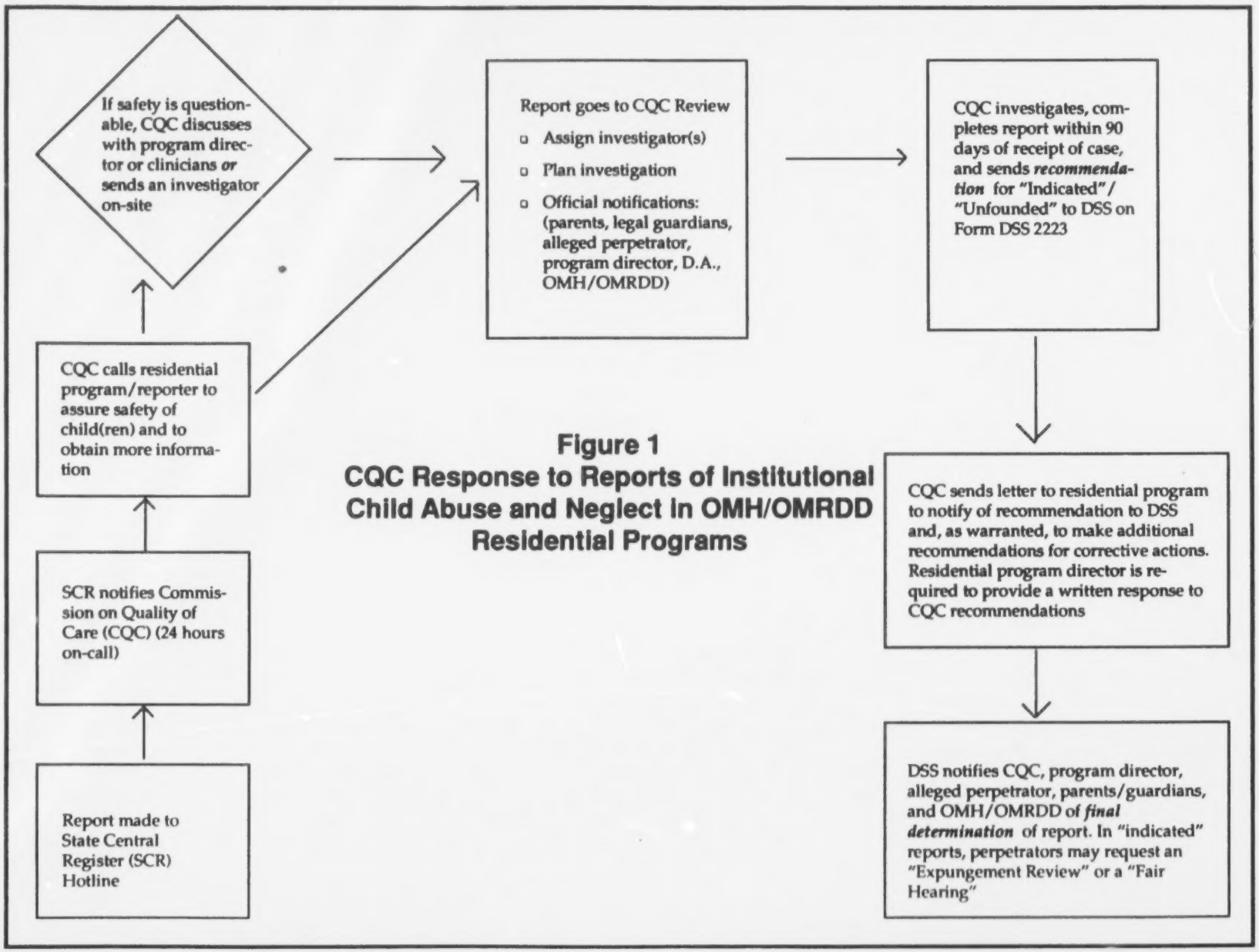

Report made to State Central Register (SCR) Hotline
SCR notifies Commission on Quality of Care (CQC) (24 hours on-call)
CQC calls residential program/reporter to assure safety of child(ren) and to obtain more information
If safety is questionable, CQC discusses with program director or clinicians *or* sends an investigator on-site
Report goes to CQC Review
Assign investigator(s)
Plan investigation
Official notifications: (parents, legal guardians, alleged perpetrator, program director, D.A., OMH/OMRDD)
CQC investigates, completes report within 90 days of receipt of case, and sends *recommendation* for "Indicated" / "Unfounded" to DSS on Form DSS 2223
CQC sends letter to residential program to notify of recommendation to DSS and, as warranted, to make additional recommendations for corrective actions. Residential program director is required to provide a written response to CQC recommendations
DSS notifies CQC, program director, alleged perpetrator, parents/guardians, and OMH/OMRDD of *final determination* of report. In "indicated" reports, perpetrators may request an "Expungement Review" or a "Fair Hearing"

Figure 1
CQC Response to Reports of Institutional Child Abuse and Neglect in OMH/OMRDD Residential Programs

The CAPA legislation also requires the Commission to notify "forthwith" the parents or legal guardians of the alleged child victim(s) and the alleged perpetrator ("subject") of a report. Additionally, the Commission also promptly notifies, by letter, the local district attorney, the residential program director, and the respective designated officials in the central offices and regional offices of OMH or OMRDD.

Finally, consistent with its own statutory authority, the Commission requires directors of facilities to respond in writing to any recommendations for corrective or preventive action put forth in its final reports. Periodically, the Commission also conducts on-site follow-up reviews of promised improvements made in response to its findings.

Reported Cases

(October 1, 1986 - September 30, 1989)

In the first three years of the implementation of the CAPA legislation, a total of 850 cases of institutional child abuse and neglect were reported to the Commission. Reports filed by mental health facilities constituted 81 percent of these reports.

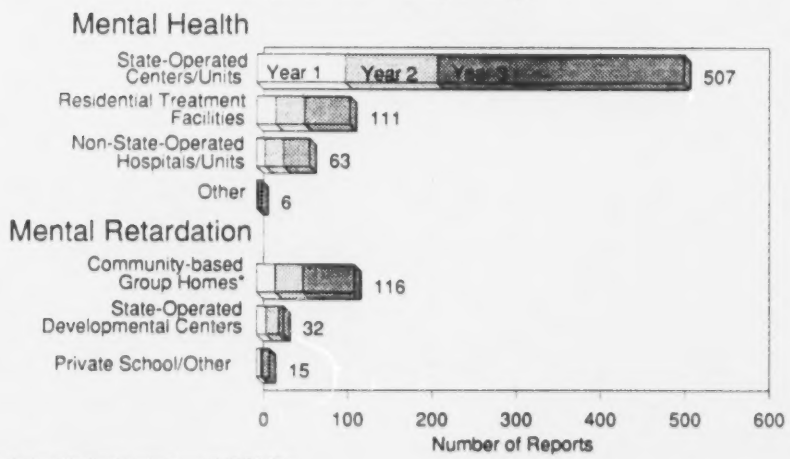
This report discusses the profile of the allegations of institutional child abuse and neglect which were received by the Commission in the first three years of the implementation of the CAPA legislation (October 1, 1986 - September 30, 1989). The findings derive from a database which the Commission established to track significant features and trends in the nature of the reports, the characteristics of the children involved, and the final determinations of its investigations. Final analysis has not been completed on reports received in Year 4 (October 1, 1989 - September 30, 1990), but in some instances the report also comments on significant deviations in reported trends which surfaced in Year 4.

In the first three years of the implementation of the CAPA legislation, a total of 850 cases of institutional child abuse and neglect were reported to the Commission. Reports filed by mental health facilities constituted 81 percent of these reports. State-operated children's psychiatric centers and children and youth psychiatric units, alone, accounted for 60% of the total reports received (Figure 2).

Figure 2

Reports by Year and Program Type

(Oct '86 - Sept '89)



*Includes Medicaid reimbursed ICF/MR's (111) and traditional group homes (5).

The number of reports received by the Commission increased steadily from Year 1 to Year 3, with the greatest increase occurring in Year 3 when the number of cases reported more than doubled.[3] (Notably, the trend of increasing reports did not continue through Year 4, when the number of total reports received, 277 reports, returned to a level similar to that reported in Year 2.)

To gain a better perspective on the number of reports, the Commission also attempted to derive comparative abuse and neglect reporting rates for children living in different types of mental health and mental retardation residential programs. This analysis revealed a wide variation in reporting rates across different types of programs although, as a whole, mental health children's residential programs tended to have much higher reporting rates than mental retardation programs. As shown in Figure 3, as a group, residential treatment facilities had the highest average annual reporting rate of nearly 9 reports per 100 children served, while licensed children's psychiatric units and hospitals had the lowest rate of less than 1 report per 100 children served. This analysis also indicated that for most mental health residential program models, the reporting rate was considerably higher than the 1989 annual statewide reporting rate to the State Central Register for all child abuse and neglect reports.[4]

This analysis revealed a wide variation in reporting rates across different types of programs although, as a whole, mental health children's residential programs tended to have much higher reporting rates than mental retardation programs.

Nature of the Reports

Slightly more than half of the 850 reports (55%) received by the Commission in the first three years of CAPA implementation referenced an allegation of *physical* abuse; 22% of the reports referenced an allegation of inappropriate restraint or seclusion; and 15% of the reports referenced an allegation of adult-to-child sexual abuse. In addition, an allegation of staff neglect contributing to child-to-child sexual activity was noted in 14% of the reports, and another 21% of the reports referenced an allegation of staff neglect not associated with child-to-child sexual activity.[5]

Approximately two-thirds (68%) of the 850 reports resulted in no reported physical injury to the alleged child victim or victims. Twenty-five (25) percent of the reports involved an injury requiring first aid treatment, and 6% of the reports involved a more serious injury. Two reports (less than 1%) involved the death of a child.

[3] OMH officials, in commenting on the draft report, stated their belief that the increase in reporting in their facilities in Year 3 reflected OMH's increased training efforts to encourage reporting in their state-operated and -licensed programs.

[4] Appendix C provides an analysis of reporting rates by program modality for each of the three years reviewed.

[5] The total percentage exceeds 100% because many of the reports received (54%) referenced two or more different types of abuse or neglect.

Figure 3

Annual Reporting Rates by Residential Program Modality (October 1986 - September 1989)*

MENTAL HEALTH FACILITIES	*Reports Filed*	*Average Annual Reporting Rate Per 100 Children Served*
Children's Psychiatric Centers	350	6.86
State Children and Youth Units	157	3.66
Residential Treatment Facilities	111	8.68
Licensed Children's Psychiatric Units/Hospitals	63	.31
Others	6	3.15
MENTAL RETARDATION FACILITIES		
Developmental Centers	32	2.12
Intermediate Care Facilities	111	4.31
Community Residences	5	1.24
Private Schools/Others	15	1.99
* * * * *		
STATEWIDE	130,315	2.78
(Based on reports to the State Central Register in 1989)		(Per 100 non-institutionalized children in NYS)

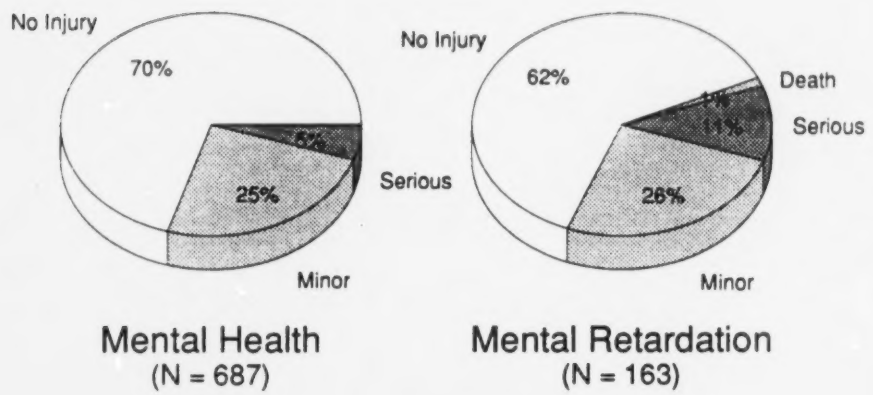
*Appendix C provides an analysis of reporting rates by program modality for each of the three years reviewed.

Reports filed by mental retardation facilities were more likely to involve an injury than reports filed by mental health facilities. These reports were also more likely than mental health facility reports to involve a serious or fatal injury.

Further analysis indicated that the type of allegation reported was associated with the likelihood of a physical injury to the child. Reports involving an allegation of inappropriate restraint and/or seclusion or an allegation of physical abuse were the *most likely* to result in a physical injury (47% and 44%, respectively), whereas reports alleging adult-to-child sexual abuse and staff neglect, contributing to child-to-child sexual activity, were the *least likely* to result in a physical injury (only 10% and 11% of these reports, respectively).

Analysis also showed that the nature of reports filed by mental health and mental retardation facilities differed significantly. Reports filed by mental retardation facilities were more likely to involve an injury than reports filed by mental health facilities (38% versus 30%). Mental retardation facility reports were also more likely than mental health facility reports to involve a serious or fatal injury (12% versus 5%, $X^2 = 17.53$, $df = 4$, $p < .01$) (Figure 4). (Of note, both cases which resulted in the death of an alleged victim were reported by mental retardation facilities.)[6]

Figure 4
Reports by Severity of Injuries and by Auspice
(Oct '86 - Sept '89)

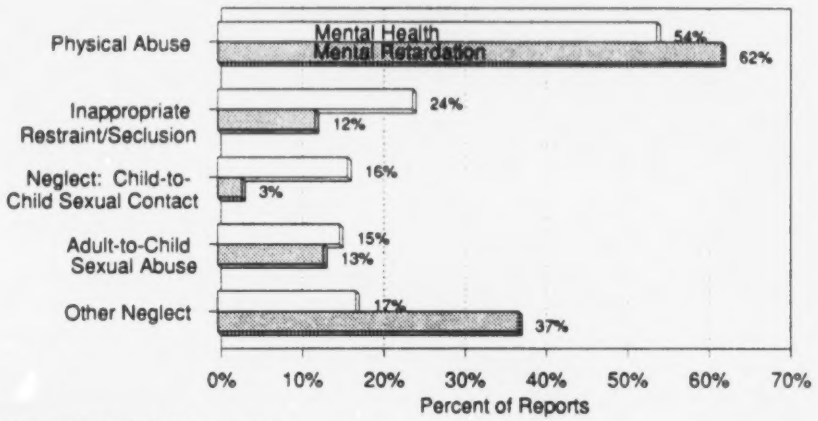


[6] Of the two reports involving a child's death, one report was indicated and one was unfounded. The indicated report involved a child who drowned when she was left unattended in a Century Tub, contrary to stated program policy. The unfounded report involved a child who choked to death after eating a piece of orange offered to her by a staff person. The case was unfounded because it was not clear that the staff person was fully aware of the child's dietary restrictions.

Figure 5

Reports by Type of Allegation and by Auspice

(Oct '86 - Sept '89)



* Total percentages exceed 100%, as many reports referenced two or more different types of allegations.

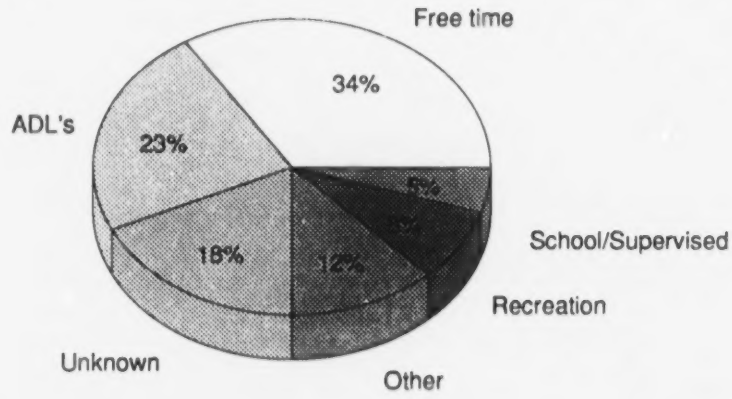
As shown in Figure 5, auspice also appeared to influence the type of allegations reported. Mental health facilities were *more likely* to report allegations of inappropriate restraint and/or seclusion and allegations of staff neglect contributing to child-to-child sexual activity. In contrast, mental retardation facilities were *much more likely* to report allegations of staff neglect not associated with child-to-child sexual activity.

Circumstances of the Alleged Abuse or Neglect

Almost all of the alleged incidents (96%) took place in the residential program where the child was living, and, for over half of the reports, at the time of the alleged incident children were engaged in "free time" (34%) or "activities of daily living," like eating, bathing, dressing (23%) (Figure 6). "Free time" was especially likely to be associated with reports alleging physical abuse (39%) and inappropriate restraint or seclusion (45%).

In contrast, many fewer of the alleged incidents occurred during a planned recreational activity (8%) or during school or other structured activities (5%) when professional clinical staff were more likely to be on the scene. Together these findings suggest that the most vulnerable times for institutional child abuse and neglect allegations are when direct care staff are left on the living unit alone, without planned activities for the children.

Figure 6
Reports by Activity Type*
(Oct '86 - Sept '89)



(N = 850)

*Type of activity refers to the activity the alleged victim was involved in at the time of the alleged incident.

The Alleged Child Victims

In total, the 850 reports cited 1,139 alleged child victims, with 20% of the reports citing more than one alleged child victim. These 1,139 children references represented a total of 823 unique children, 640 of whom were cited in only one report and 183 of whom were cited in two or more reports (Figure 7).

Notably, these latter 183 children accounted for 44% of the 1,139 alleged child victim references in the 850 reports. From another perspective, at least one of the alleged "repeat" child victims was represented in 47% of the 850 reports. The analysis also identified 32 children who were referenced as alleged victims in four or more cases. These 32 children accounted for only 4% of the 823 unique children referenced, but they are referenced in 132 or 16% of the total 850 filed reports (Figure 8).

Figure 7

Number of Alleged Child Victims
(Oct '86 - Sept '89)

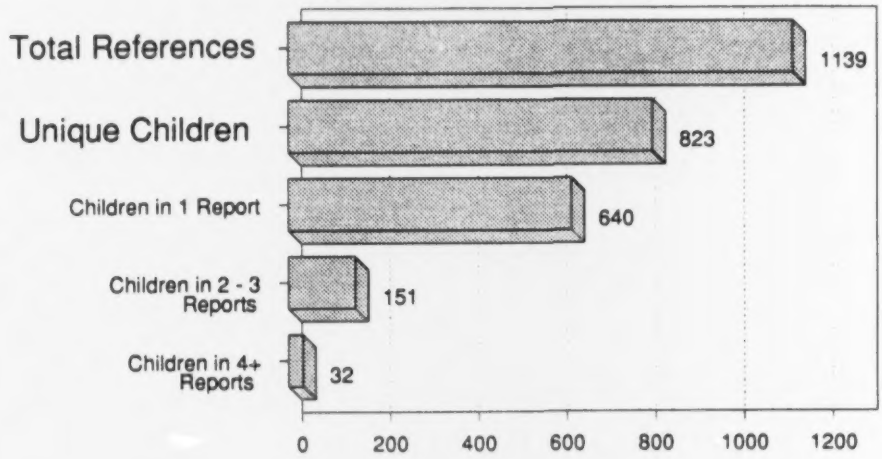
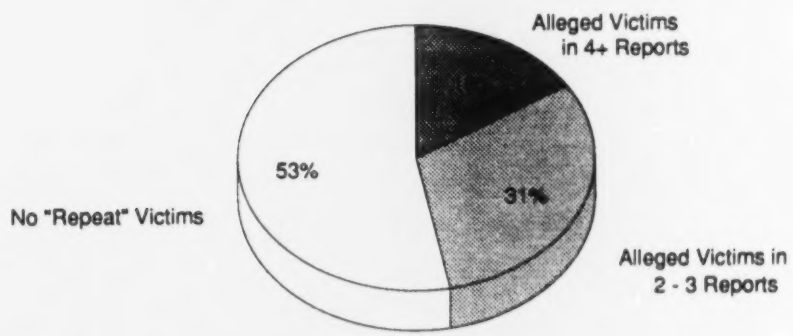


Figure 8

Percent of Reports by Presence of "Repeat" Victims
(Oct '86 - Sept '89)



(N = 850)

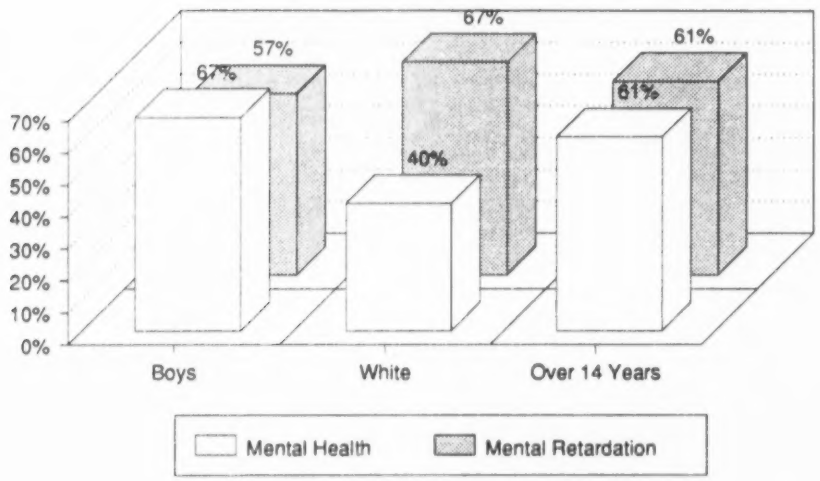
The demographic profile of the 1,139 alleged child victim references in the 850 reported cases indicated that 65% were boys, and that 61% were 14 years of age or older. Forty-five (45) percent were white; 42% were non-white; and for 13% of the references, the child's race was recorded as "unknown."[7] Only 13% of the 1,139 alleged child victims were 10 years of age or younger.

Although the analysis showed non-significant statistical differences in the ages of the alleged child victims residing in mental health versus mental retardation facilities, the other demographic differences did surface by auspice of program (Figure 9).

- Although boys comprised two-thirds (67%) of the alleged child victims in mental health facility reports, only slightly more than half (57%) of the alleged child victims in mental retardation facility reports were boys ($X^2 = 11.67$, df = 2, $p < .01$).

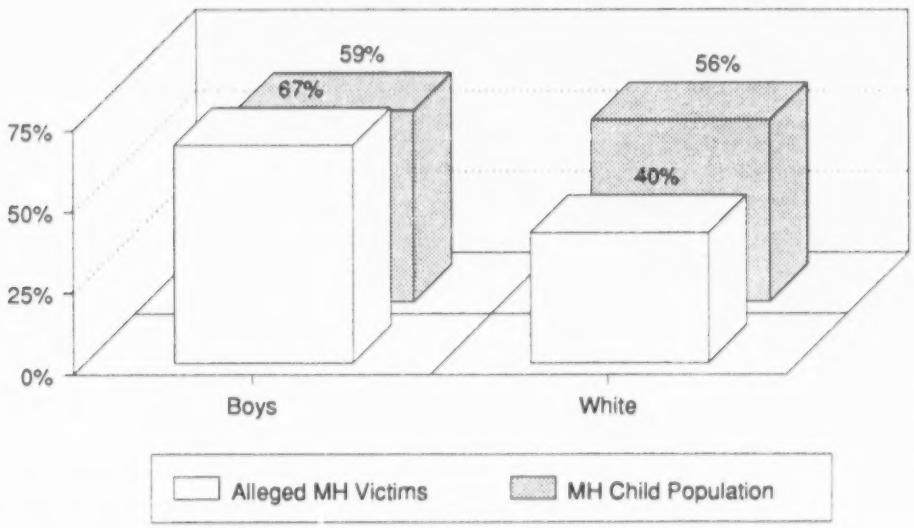
- White children represented 40% of the alleged victims referenced in mental health facility reports versus 67% of the alleged victims referenced in mental retardation reports ($X^2 = 50.42$, df = 6, $p < .001$).

Figure 9
Victim Demographics by Auspice
(Oct '86 - Sept '89)



[7] Only a slightly different profile emerges when one adjusts the statistics to eliminate duplicative counts of alleged child victims cited in more than one case. This analysis, based on the set of 823 unique alleged child victims, found that 64% of the children were boys; that 57% were 14 or older (in the first case in which they were cited); and that 50% were non-white.

Figure 10
Mental Health Alleged Victims
vs Mental Health Population Served



As shown in Figure 10, the data also indicated that, compared to the population served, boys seem to be overrepresented in reports filed by mental health programs, while white children seem to be underrepresented. Specifically, 59% of children served in state children's psychiatric centers and units and state-licensed children's residential treatment facilities (RTFs) are boys. And, white children comprise 56% of the children served by these programs.

"Repeat" Alleged Child Victims

Not surprisingly, Commission staff, over the course of three years, came to be familiar with many of the children referenced in more than one report to the State Register. This familiarity brought an awareness of the difficult times these children experienced and, in many respects, continued to endure (Figure 11). It also soon became apparent that the relatively small number of "repeat" alleged child victims had an enormous impact on the reports filed with the State Register and that, for this reason alone, they warranted further study. As noted above, the 183 "repeat" alleged child victims were represented in 47% of the total cases received by the Commission in the first three years of CAPA's implementation.

Figure 11
High Risk Institutionalized Children

These children, whose names have been changed and whose backgrounds have been slightly altered to protect their confidentiality, appeared in at least three reports filed with the State Central Register and investigated by the Commission during the first three years of CAPA's implementation. Better than statistics, the stories of these children illustrate the multiple difficulties they have to overcome.

- **"Ron"**

  Ron, a mentally retarded young man, lived at home until he was 16. According to his records, at age 6, Ron developed bone cancer, and his treatment resulted both in the amputation of his leg and a drug overdose which caused his mental retardation. In high school, Ron has had many adjustment problems, and he had been suspended from school twice due to his aggressive behavior.

  At age 16, Ron moved into a community-based ICF-MR. Within three years of his placement, he had been involved in three State Hotline reports. In one "indicated" case, staff reportedly jumped on top of Ron in bed and pushed their knees into his stomach. In another case, it was confirmed that staff compelled Ron, who had refused to go to bed, to stay awake all night. The case was not indicated, as there was not sufficient evidence of serious harm. The third case alleging that a staff person hit Ron across the head was "unfounded."

- **"Julio"**

  Just 11 years old, Julio was first admitted to a state children's psychiatric center due to allegations of familial abuse. Long before this admission, however, Julio suffered from behavioral problems at home and at school, and his records document many problems, ranging from a low tolerance for frustration to a short attention span to hyperactivity to frequent fighting.

  Within a year of his admission to the state center, Julio had been involved in a report of abuse to the State Hotline and, over the next two years, he was cited as an alleged victim in four more reports. Four of these five reports were indicated. They ranged from an incident where Julio, who had been chasing another child with a fork, was inappropriately restrained on the floor sustaining a head injury, to an incident where a staff person lost his temper with Julio's antics and threw his keys at him. In another incident, a staff person, watching TV, did not notice a young girl patient and Julio,who were both to be under constant supervision, leave the cottage and engage in sexual play.

  Today, at age 15, Julio remains at the state children's psychiatric center. He was once transferred to a community residential treatment facility, but complaints of severe management and adjustment problems sent him back to the state children's center within one month.

- **"Edward"**

  Like Julio, Edward has a long history of emotional problems. When he was just two, Edward's mother was violently murdered, and he and his older brother went to live with his grandmother. By the second grade, he had been placed in special educational classes due to his emotional and behavioral problems and, as he grew older, he became more and more unmanageable at home. Eventually, his grandmother filed a PINS petition for Edward because his behavior had become dangerous. Soon afterward, he was referred to an outpatient psychiatric clinic.

  Edward was first admitted to a state children's psychiatric center at age 12. He had surfaced in a State Hotline report at age 14 during his second admission to the center and, over the next two years, Edward was involved in seven abuse reports to the State Hotline. Although only one of these reports was indicated, most of the reported "events" were confirmed. In one report he was fighting with another child and received a bloody lip; in another report he was allegedly choking another child; in two reports he was physically assaulted by groups of children on the unit; and in two other reports he was engaged in sexual activities with other children. While supervisory neglect was alleged in all of these cases, extenuating circumstances, including late reporting, made it difficult to sustain a case against a specific employee.

Although the profile of "repeat" alleged child victims showed no significant differences by sex, "repeat" alleged child victims were *significantly older* (at the time of their first report) than other alleged victims ($X^2 = 18.08$, df = 5, $p < .01$), and they were also *significantly more likely to be non-white* ($X^2 = 48.47$, df = 6, $p < .001$) (Figure 12).

- Ninety (90) percent of the "repeat" alleged child victims were over 10 years of age compared to 77% of the children cited in only one case.

- Fifty-eight (58) percent of the "repeat" alleged child victims were non-white compared to only 34% of the alleged victims cited in only one case. (In total, 39% of the 823 unique children in the database were non-white.)

The Commission discovered that, although "repeat" alleged child victims were relatively common in reports filed by both mental health and mental retardation facilities, they were significantly more common in mental health facility reports.

There were also some significant differences in the types of allegations associated with "repeat" alleged child victims. "Repeat" alleged victims were *more likely* than other alleged victims to be involved in allegations of staff neglect, contributing to child-to-child sexual activity (21% versus 7%, $X^2 = 35.08$, df = 2, $p < .001$), but they were *less likely* to be involved in allegations of physical abuse (49% versus 61%, $X^2 = 10.83$, df = 1, $p < .001$) and adult-to-child sex (11% versus 18%, $X^2 = 35.08$, df = 2, $p < .001$.).

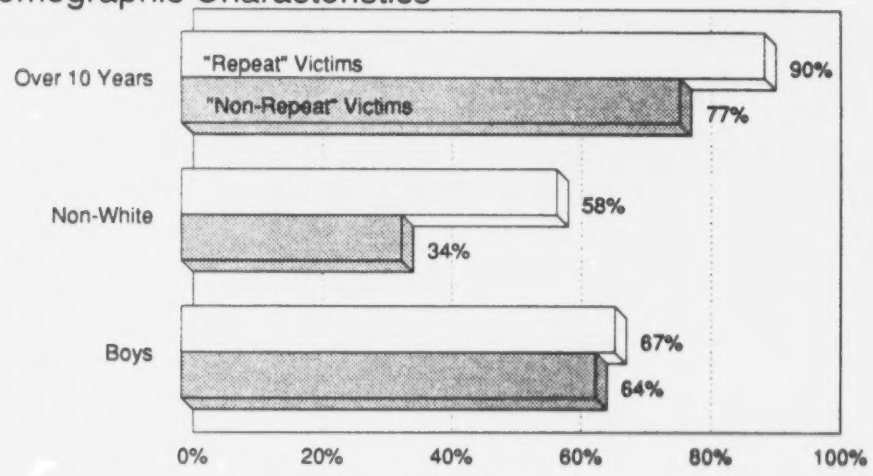
The Commission also discovered that, although "repeat" alleged child victims were relatively common in reports filed by both mental health and mental retardation facilities, they were significantly more common in mental health facility reports ($X^2 = 55.72$, df = 1, $p < .001$) (Figure 13). Over half of the reports filed by mental health facilities (54%) referenced a "repeat" alleged child victim compared to only 21% of the reports filed by mental retardation facilities.

- Approximately 75% of the cases reported by state-operated children's psychiatric centers and children and youth units referenced at least one "repeat" alleged child victim.

- From another perspective, ninety-two (92) percent of the 183 "repeat" children resided in some type of state-operated or state-licensed mental health facility, and 77% of these children were residing in state-operated children's psychiatric centers or children and youth psychiatric units. Only 15 of the 183 "repeat" alleged children (8%) were residing in a mental retardation facility.

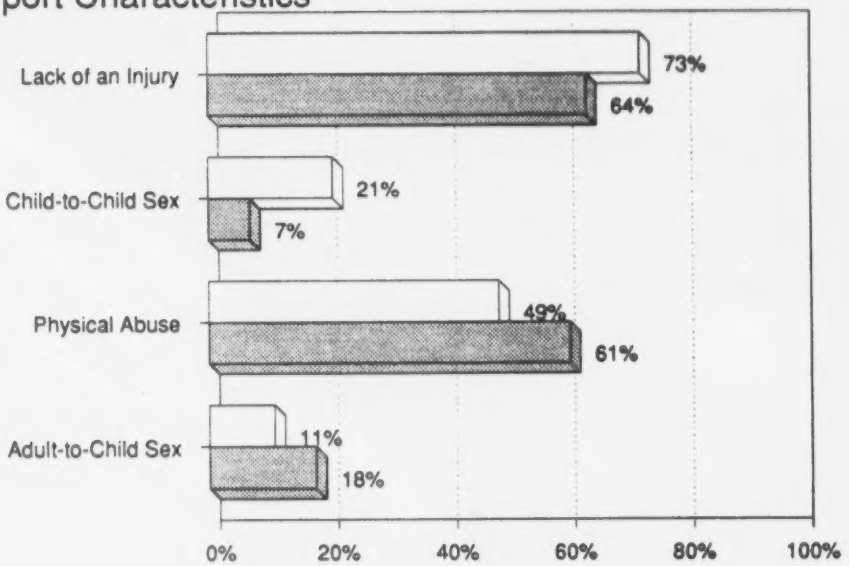
Figure 12
"Repeat" vs "Non-Repeat"
Alleged Child Victims

Demographic Characteristics



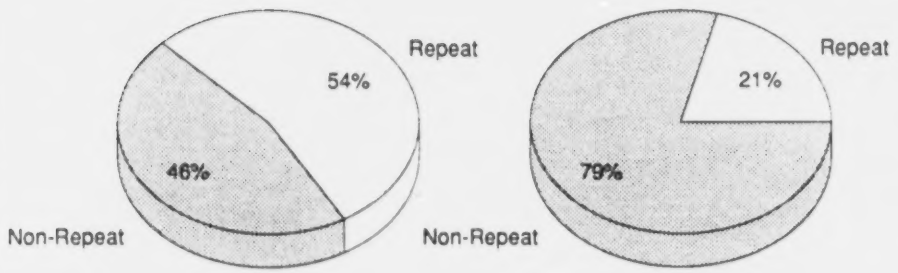
(N = 823 Children)

Report Characteristics



(N = 850 Reports)

Figure 13
"Repeat" vs "Non-Repeat" Alleged Child Victims by Auspice



Mental Health
(N = 687 Reports)

Mental Retardation
(N = 163 Reports)

Reflective of the types of reports most likely to reference "repeat" alleged victims, the analysis also showed that "repeat" alleged victims were also *significantly more likely* to be cited in reports referencing no injury or less serious injuries ($X^2 = 10.74$, df = 4, $p < .05$).

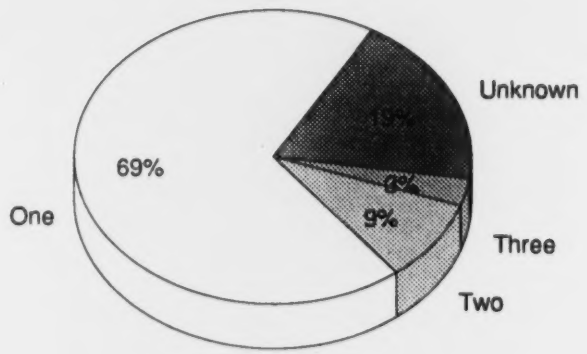
- Seventy-three (73) percent of the cases involving at least one "repeat" alleged victim referenced no injury compared to 64% of the other cases.
- Only 5% of the cases involving a "repeat" alleged victim referenced a serious injury or death compared to 8% of the other cases.

Alleged Perpetrators

Two-thirds (69%) of the 850 reports identified only one employee as the alleged perpetrator; 9% of the reports identified two employees as the alleged perpetrators; and 3% of the reports identified three employees as the alleged perpetrators. In the remaining 164 reports (19%), the identity of the alleged perpetrator(s) was unknown (Figure 14).

In total, 628 unique employees were identified as alleged perpetrators. Of these 628 employees, 512 (82%) were cited in only one report, but 116 employees (18%) were cited in two or more reports, with one "repeat" alleged perpetrator cited in *nine reports*.

Figure 14
Reports by Number of Alleged Perpetrators per Report



Percent of Reports
(N = 850)

Reports involving repeat alleged perpetrators were more likely to allege physical abuse or inappropriate restraint, and they were much more likely to emanate from mental health than mental retardation facilities.

Data analysis also showed a number of significant differences in reports involving "repeat" alleged perpetrators. Although these reports did not differ significantly from other reports in terms of their indication rates (26% versus 23%) or their seriousness (as reflected in reported physical injuries to the children involved), reports involving "repeat" alleged perpetrators were more likely to allege physical abuse or inappropriate restraint, and they were much more likely to emanate from mental health than mental retardation facilities.

- Sixty-three (63) percent of the reports involving a "repeat" alleged perpetrator alleged physical abuse, compared to only 51% of the reports not involving a "repeat" alleged perpetrator.

- Twenty-five (25) percent of the reports involving a "repeat" alleged perpetrator alleged inappropriate restraint or seclusion, compared to only 16% of the reports not involving a "repeat" alleged perpetrator.

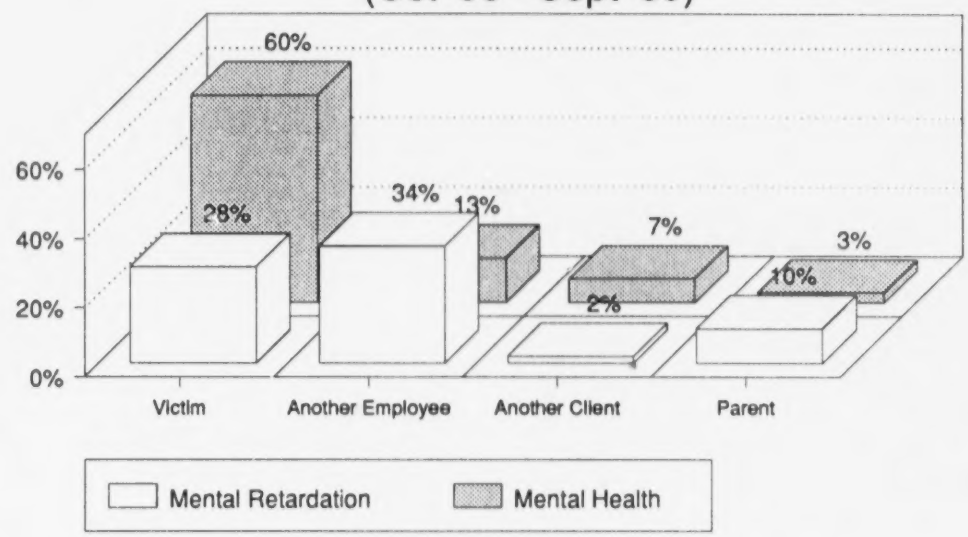
- Thirty-eight (38) percent of the reports filed by mental health facilities, compared to only 15% of the reports filed by mental retardation facilities, involved a "repeat" alleged perpetrator.

Case "Reporters"

The initial "reporter" (source) of most reports received (54%) was the alleged child victim. In 17% of the reports, facility staff (other than alleged perpetrators) were the initial "reporters." Less common initial "reporters" included other children (6%), parents (4%), and outside hospital staff (not of the residential facility) (3%). The initial "reporter" was reportedly "unknown" in 10% of the reports.

These above statistics on initial "reporters" are largely predicated on the trends in reports filed by mental health facilities, which comprised 81% of the total reports, and significant differences surfaced in reports filed by mental retardation facilities ($X^2 = 129.33, df = 13, p < .001$) (Figure 15).

Figure 15
Reports by Initial "Reporter"
and by Auspice
(Oct '86 - Sept '89)



- Whereas alleged child victims initially reported 60% of the reports filed by mental health facilities, they initially reported only 28% of the reports filed by mental retardation facilities.
- While facility employees initially reported only 13% of the reports filed by mental health facilities, these staff initially reported 34% of the reports filed by mental retardation facilities.
- Parents were also more likely to be initial "reporters" in reports filed by mental retardation facilities.

In large parts, these differences reflect differences in the children served in mental retardation versus mental health programs. For example, many more of the children served in mental retardation programs are non-verbal or have other disabilities which limit self-reporting. There is also a greater percentage of children served in mental retardation programs with involved families.

The data suggest that administrators in all facilities, and especially mental health facilities, may wisely choose to invest more of their training resources for identifying and reporting instances of possible abuse and neglect with the children they serve.

The analysis also indicated that alleged child victims were *most likely* to be the initial "reporters" in reports involving allegations of physical abuse (59%), adult-to-child sexual abuse (61%), and inappropriate restraint and/or seclusion (64%). Conversely, alleged child victims were *less likely* to be the initial "reporters" in reports involving an allegation of staff neglect, not associated with child-to-child sexual activity (25%). In these neglect reports, facility employees, parents, and anonymous reporters played a more significant role as initial reporters. (In total 44% of these neglect reports were initially reported by employees, parents, and anonymous "reporters.")

Due to standard practices in most residential facilities, initial "reporters" were often *not* the individuals who called the State hotline to report the case. In nearly two-thirds of the reports (66%), facility staff actually filed the reports. Other less common callers to the hotline included Commission staff (17% of the reports), parents (4% of the reports), and outside hospital staff (3% of the reports). Notably, only 2% of the callers asked to remain anonymous.

While these data support the importance of training programs which help employees identify situations of possible abuse or neglect, they also indicate that, in most cases, employees will be the "receivers" of initial reports and they will play the important role of following up with their supervisors and/or calling the hotline. In this regard, it may be helpful to augment employee training programs with a greater emphasis on *how to follow up on reports they receive from children, parents, or fellow employees and how to file a complete and accurate report with the State Central Register*. Commission investigations have also often revealed that reporting problems at facilities center, not so much on initial reporting, as on the follow-through of senior staff on reports received.

Specifically, in many cases where reports were not properly filed with the State Register, the Commission discovered that these incidents had been communicated verbally or on daily logs by direct care staff, but they had not been addressed by senior staff.

The data also suggest that administrators in all facilities, and especially mental health facilities, may wisely choose to invest more of their training resources for identifying and reporting instances of possible abuse and neglect with the children they serve. They also suggest that more training for parents of the children served, especially in mental retardation facilities, may be warranted.

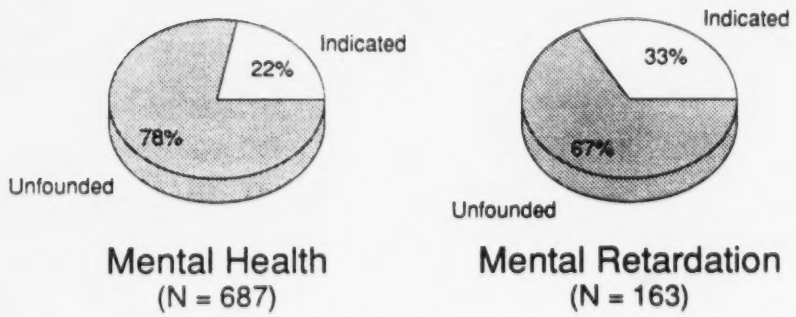
CQC Investigation Findings

Over the first three years of the CAPA legislation implementation, the Commission made recommendations to indicate 24% of all reports received.

In closing its investigations, the Commission is charged by the CAPA legislation to make a recommendation to the Department of Social Services as to whether the report should be "indicated" (confirmed) or "unfounded." These recommendations are subsequently reviewed by the Department of Social Services, which issues the final determination of the report.

Over the first three years of the CAPA legislation implementation, the Commission made recommendations to indicate 24% of all reports received. There were significant differences in recommended indication rates by program auspice, with reports filed by mental retardation facilities being more likely to be indicated than reports filed by mental health facilities (33% versus 22%, $X^2 = 8.87$, $df = 1$, $p < .01$) (Figure 16). More discrete analysis indicated that this trend was entirely accounted for by community-based mental retardation facility reports which had a 34% indication rate. The 32 reports filed by state developmental centers actually had a *lower than average* indication rate of 19%.

Figure 16
Reports by CQC Recommendations to DSS and by Auspice



Among mental health facilities, reports filed by state-operated children's psychiatric centers and state-licensed residential treatment facilities had *average* indication rates of 24% and 23%, respectively. In contrast, reports filed by children's psychiatric units in state-licensed hospitals had a *higher* than average indication rate of 34%, and reports filed by state-operated children and youth psychiatric units (affiliated with state adult psychiatric centers) had a *lower* than average indication rate of 10%.

Analysis also showed that there were significant differences in the indication rates over the three years studied ($X^2 = 52.81, df = 2, p < .001$). Reports filed in Year 2 had the highest indication rate of 41%, whereas reports filed in Year 3 had the lowest indication rate of 15%. Reports filed in Year 1 had a 26% indication rate.

In a number of reports investigated by the Commission, the alleged abusive or neglectful incident was determined to have occurred, but the reports were closed with a recommendation of "unfounded" because all of the requirements to link a specific custodian to causing the requisite level of harm by other than accidental means could not be met .

In interpreting these indication rates, it is important to emphasize that the Commission is charged to make its recommendations to the Department of Social Services in accord with the definitions of institutional child abuse and neglect in the CAPA legislation. As explained earlier (see pages 3-4), in instances where the investigation revealed that the alleged incident did occur and was harmful to the child, the report may be "unfounded" if some credible evidence could not substantiate that: (1) a specific "custodian" was responsible; *or* (2) that his/her actions were due to "other than accidental means;" *or* (3) that the harmful effect on the child met the standard of serious injury, disfigurement, or impairment, or substantial risk of serious injury, disfigurement, or impairment or risk of impairment of the child's physical or emotional health; *or* (4) in instances of alleged sexual abuse, that the alleged act reflected a violation of relevant sections of the state's penal code.

In a number of reports investigated by the Commission over the past three years, the alleged abusive or neglectful incident was determined to have occurred, but the reports were closed with a recommendation of "unfounded" because all of the requirements to link a specific custodian to causing the requisite level of harm by other than accidental means could not be met (Figure 17). For example, in many reports of supervision "neglect" leading to the harm of a child, it was not possible to identify the specific staff person who breached a specific duty to a child. This is particularly the case in situations where overall facility management is weak in clarifying specific staff responsibilities or where the allegation itself is reported late, clouding staff memories of who exactly was responsible for supervising a particular child. In other reports, it may be difficult to prove that the action was "due to other than accidental means" because facility training and/or supervisory practices may raise doubts as to the alleged perpetrator's full understanding of what he/she was expected to do or how he/she was expected to do it.

Figure 17
"Confirmed" Unfounded Reports

- An investigation confirmed an allegation that an employee yelled, pushed, and slapped a child about the head and arms. The incident was witnessed by three clinical staff, and the child sustained a small scratch. Although the allegation was confirmed, the report was "unfounded" as the level of harm or substantial risk of harm to the child did not meet the standard in the CAPA legislation. [Subsequently, the alleged perpetrator was counselled by the facility for inappropriate conduct toward a child.]

- An investigation confirmed a parent's allegation that her daughter, a child with a diagnosis of Pica (the tendency to eat non-edible objects), had been allowed to eat a piece of "blue foam." Although there was a behavior plan specifying special supervision, program staff and the child's record indicated that the Pica behavior of the child had recently increased and the level of supervision was not adjusted accordingly. While the allegation was confirmed, the case was "unfounded." The direct care staff responsible for supervising this child were following the existing behavior plan correctly, but the plan was not amended to respond to the change in the child's behaviors and her need for increased supervision. Due to staff turnover and resultant changes in clinical staff responsibilities, no one person could be identified as responsible for ensuring that this change was made in the child's treatment plan and therefore an identification of a specific "perpetrator(s)," a requirement for "indicating" an allegation of child abuse or neglect to the Register, could not be made by the Commission. [Subsequent to the Commission's report, the facility did review and revise the child's behavior plan, and provide facility staff additional training.]

- An investigation confirmed that a young profoundly retarded girl who was bleeding vaginally had suffered a .9 cm. puncture wound in her cervix. The physician could place the estimated time of the injury, and he indicated that the injury could not have been self-inflicted due to the child's limited manual dexterity. Although the investigation determined that two staff were responsible for the care and supervision of the child during the time period when the injury occurred, there were no staff assignment sheets, and it was not possible to establish with some credible evidence which staff person had provided personal care to the child the night in question. Thus, while the Commission could confirm the serious injury to the child and that it was most likely inflicted by an intentional harmful action of another, the report was unfounded because it was not possible to establish, with some credible evidence, the individual "custodian" who was responsible. [Subsequent to the investigation, the facility instituted staff assignment sheets, improved on-site supervision of staff, and revised services documentation practices.]

Finally, in many cases coming before the Commission, the investigation revealed that the alleged incident did occur and that it was reasonably clear the alleged perpetrator was aware of his/her responsibilities and his/her misconduct could not be deemed accidental, but that the level of harm or potential harm to the child was not sufficient to meet the test of the CAPA definitions. For example, the staff person who knowingly inappropriately restrains a child, resulting in minor cuts or bruises, may not meet this test. As another example, the report of a staff person who knowingly fails to administer a specific medication to a child may not meet this test if failure to receive the medication would result in no substantial lasting harm.

Notwithstanding the above reservations in interpreting indication rates, the Commission was curious to determine if certain characteristics of the reports received and/or the children involved were associated with their likelihood to result in a recommendation of indication. This investigation proved fruitful as the Commission found that many variables, ranging from the presence of an injury to the type of allegation to who "initially reported" the allegation, were significantly associated with higher or lower indication rates.

The Commission found that many variables, ranging from the presence of an injury to the type of allegation to who "initially reported" the allegation, were significantly associated with higher or lower indication rates.

- Reports involving death or a serious injury had a significantly higher indication rate of 36% than reports involving no reported injury which had an indication rate of 21% ($X^2 = 12.74$, df = 3, $p < .01$). (Reports involving a less serious injury had an indication rate of 30%, still *well above the average* indication rate of 24%.)

- While reports alleging most types of allegations had indication rates in the narrow range of 21% to 26%, reports alleging staff neglect contributing to child-to-child sexual activity had a *lower than average* indication rate of 15%, and reports alleging adult-to-child sexual activity had a *higher than average* indication rate of 34% ($X^2 = 12.35$, df = 2, $p< .001$).

- Allegations initially reported by outside hospital staff and facility employees had *higher than average* indication rates of 38% and 31%, and cases initially reported by anonymous persons and parents had *lower than average* indication rates of 0% and 3%, respectively. ($X^2 = 28.04$, df = 13, $p < .01$).

Somewhat surprisingly, the analysis showed no significant relationship between indication rates and the age, sex, or race of the alleged child victims. The analysis did reveal, however, that reports involving repeat alleged child victims were *less likely* to be indicated than reports involving children referenced in only one report (20% versus 27%, $X^2 = 5.64$, df = 1, $p < .02$). Interestingly, however, further analysis showed little and non-significant differences in the indication rates of repeat alleged child victims for the first case in which they were cited (25% versus 26%).

Recommendations for Corrective and Preventive Actions

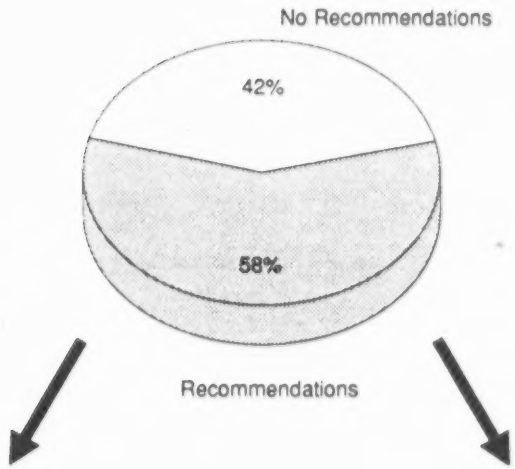
In addition to making recommendations to the Department of Social Services for the final determination of reports, where appropriate, the Commission also offers recommendations to the reporting residential facility for needed corrective and preventive actions. These recommendations may be offered in conjunction with reports where the Commission recommended "indicating" or "unfounding" to the Department of Social Services, and they address a range of issues.

The Commission made recommendations to the reporting residential facility for needed corrective and preventive actions in 58% of the 850 reports investigated.

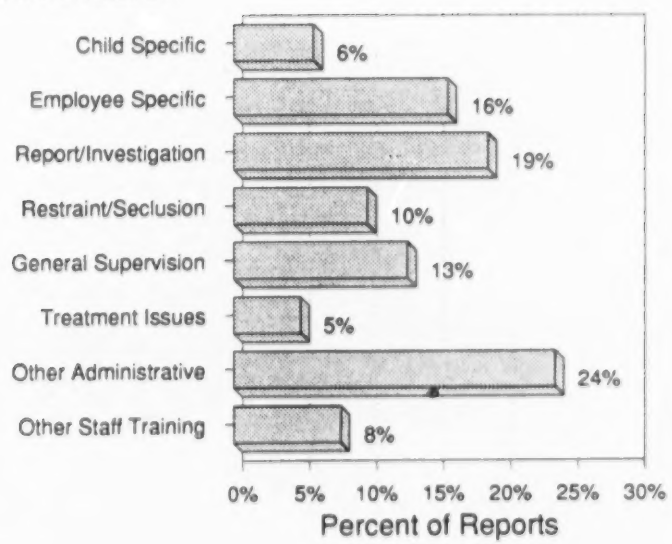
In total, the Commission made such recommendations in association with 58% or 490 of the 850 reports received in the first three years of the CAPA legislation. In 31% of the reports, the Commission made two or more recommendations for corrective or preventive action.

As shown in Figure 18, the Commission made recommendations specific to the care and treatment of individual children in 6% of the 850 reports, and it made recommendations pertinent to the supervision, training, and/or discipline of specific employees in 16% of the 850 reports. In the most cases, however, Commission recommendations were more systemic in nature, relating to overall administrative, supervisory, treatment, and/or staff training issues at the reporting program. For example, the Commission offered recommendations related to the reporting and/or investigation of allegations of child abuse or neglect in closing 19% of the 850 reports, and it offered recommendations related to other administrative procedures and practices in 24% of the 850 reports. Additionally, in 10% of the reports the Commission made recommendations pertaining to staff practices and staff training in physically intervening, restraining, and/or secluding children. In 13% of the reports, recommendations were made pertaining to the supervision of children and/or staff. In a smaller percentage of the reports, recommendations were offered pertinent to other staff training (8%) and treatment issues (5%).

Figure 18
Reports by CQC Recommendations
(Oct '86 - Sept '89)



Type of Recommendation



A fuller understanding of the impact of recommended corrective actions on the residential programs reporting allegations in the three-year period is gleaned by looking at the outcomes at individual programs. The most publicized example of these outcomes occurred at Western New York Children's Psychiatric Center.[7] At this facility, the Commission's investigations of over 32 separate child abuse and neglect reports, many involving sexual activity among young children, led to a complete change in facility management, a major restructuring of staff and child supervision procedures, clearer expectations and accountability for children's assessment and treatment, and the provision of a series of staff in-service programs which focused on the special needs of children with prior histories of physical and sexual abuse.

At Western New York Children's Psychiatric Center, the Commission's investigations led to a complete change in facility management, a major restructuring of staff and child supervision procedures, clearer expectations and accountability for children's assessment and treatment, and staff in-service programs.

The Office of Mental Health also initiated a number of statewide reforms in the wake of the Commission's investigations at Western New York Children's Psychiatric Center, including:

- the development of appropriate qualifications and performance indicators for key administrative and clinical staff in all state-operated children's psychiatric centers and units;
- development and implementation of a uniform peer review process for state-operated children's psychiatric programs to identify the strengths and weaknesses of the programs' ability to manage and treat children safely;
- formation of a Task Force to develop guidelines for staff working with sexually abused children; and,
- routine review by Central Office of all reported incidents of sexual activity among children in state-operated children's psychiatric programs.

As shown in Figure 19, major changes and reforms have also been achieved at other residential programs in response to CAPA investigations. As illustrated in these examples, these reforms have covered a range of treatment and care issues, as well as a number of different specific reforms in administrative and supervisory practices.

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[7] *Investigation into Allegations of Child Abuse and Neglect at Western New York Children's Psychiatric Center [Interim Report]*, January 1989; *Investigation into Allegations of Child Abuse and Neglect at Western New York Children's Psychiatric Center [Final Report]*, April 1990.

Figure 19
Case Examples of Corrective Actions Achieved by Several Programs

- At an OMH-operated children and youth psychiatric unit, numerous reports of children leaving the unit without consent led to many reforms, including improved accountability for staff assigned to supervise children, more structured program opportunities for children, more frequent unannounced supervisor rounds, revisions in the patient "privileges" system, and more scheduled opportunities for communication between clinical and direct care staff.
- At an OMRDD-licensed program, a report relating to a child who had a tracheostomy resulted in retraining of staff in the care and supervision of children with tracheostomies and the development of a Mealtime Assessment Team and Memo System to ensure that all staff are informed of the special personal care and feeding techniques to be used with individual children.
- At an OMH-licensed residential treatment facility, a number of reports of child-to-child sexual encounters resulted in a new staff training program in treatment issues for children with sexual abuse histories and in family life education to assist staff in helping adolescents in dealing with sexuality issues and forming healthy relationships.
- At an OMH-licensed residential treatment facility a number of reports related to the poor handling of crisis situations with children led to a new training program for staff on early crisis intervention and prevention and the program's increased supervision of employees who are known to have difficulty handling crisis situations with children.
- At an OMRDD-licensed residential school, problems with reporting and investigating serious incidents, including allegations of abuse and neglect, resulted in new procedures for staff reporting to the State Central Register, formal guidelines for the handling of injuries of unknown origin, and improved facility practices in recording written statements and documenting injuries in conducting investigations.
- At an OMH-operated children's psychiatric center, investigations led to a number of changes in staffing practices, including staff reassignments to ensure adequate staffing early in the morning, facility staff supervision of "substitute" teachers, and retraining of staff in record documentation, behavior management, seclusion, and IM medications.
- A private psychiatric hospital, in response to reports, agreed to establish new procedures regarding 1:1 supervision orders for children, regular "hall checks," night staffing, and staff supervision. The hospital also developed new policies for the more accountable reporting, investigation, and follow up of allegations of abuse and neglect.
- At an OMRDD-licensed ICF-MR, a report related to medical care services resulted in a new policy for obtaining emergency medical consent, increased medical care staff coverage, more involvement of medical staff in the admission process, and assurances of 24-hour pharmacy services.
- At an OMH-operated children's psychiatric center, investigations of allegations have led to a variety of reforms including revised policies for routine patient checks, supervisor rounds, and daily orders for special suicidal precautions; a new policy for "reference checks" of all prospective employees; and modified guidelines for the use of seclusion, "time-out," one-person take-downs of children, and "wall restrictions."

Final DSS Determinations of the Reports

In 99 percent of 850 reports investigated by the Commission, its initial recommendation to the Department of Social Services was upheld in the Department's final determination of the case. In approximately one dozen reports, requests for expungement reviews and fair hearings have been made by "indicated" custodians.

Report Recommendations

The Commission has been frequently impressed by the vigilance and competence with which the reporting program staff immediately intervene to protect the child(ren) and ensure an objective and complete investigation of the allegation.

Over the past five years, the Commission has gained a better understanding of the nature and causes of child abuse and neglect in mental health and mental retardation residential programs. In some respects, what the Commission has learned has been heartening. Most reports we have been called upon to investigate have not resulted in serious physical injuries to children, and only a minority of the reports appear to involve premeditated actions designed to physically harm or sexually abuse children. The Commission has also been frequently impressed by the vigilance and competence with which the reporting program staff immediately intervene to protect the child(ren) and ensure an objective and complete investigation of the allegation.

At the same time, certain systemic problems and concerns have become evident in the course of these investigations:

(1) Confusion Over Reporting

There remains significant confusion among front line staff in the field regarding the CAPA definitions of institutional child abuse and neglect. This confusion contributes to the widely variable reporting rates across programs, and it is also reflected in the fluctuation in the number of reports called into the State Central Register and referred to the Commission in each of the first three years of CAPA's implementation.

Continued training, especially for professional staff which is now required by State law, should provide some relief from this confusion. It also is recommended that both the Commission and the Department of Social Services be allowed, upon receiving a report from the State Central Register and following up with the reporter and the facility, to make an initial determination of whether the report actually conforms to CAPA definitions. Reports not meeting these criteria could be promptly removed from the Register, although the Commission and Department would be responsible for ensuring that nonconforming reports were investigated appropriately.

This change would ensure more accountable and prompt investigations of the more serious reports which do meet the CAPA definitions, and simultaneously allow a reasonable and accountable approach to the investigation of other incidents which may be filed with the State Register as a result of facility staff's desire to comply with their understanding of the law.

Recommendations:

- OMH and OMRDD should continue to provide training to professional staff in the definitions of institutional child abuse and neglect in the CAPA legislation.

- The Commission and the DSS should develop procedures which allow a preliminary review of reported cases to promptly remove cases from the Register which do not meet the standards in the CAPA definitions of institutional child abuse and neglect, while simultaneously assuring that all non-conforming reports are investigated appropriately.

Even well-managed and well-staffed children's residential programs can be vulnerable to problems of underreporting of abuse and neglect; yet, certain steps can be taken which can minimize this risk.

(2) Underreporting in Some Programs

Beyond the confusion over the CAPA definitions, the data also indicate that failure to report allegations which clearly meet the statute's definitions may also be a problem in some programs. The Commission found widely variable reporting rates among different residential program modalities, including especially low rates for state developmental centers and state-licensed children's psychiatric units in acute care hospitals and private psychiatric hospitals. Additionally, a significant number of state-licensed programs serving children had not filed a single report over the full three-year period covered by this report.

Even well-managed and well-staffed children's residential programs can be vulnerable to problems of underreporting of abuse and neglect; yet, certain steps can be taken which can minimize this risk. The first line of prevention is appropriate training. The data on the child abuse and neglect reports received by the Commission suggest that enhanced training for the children served, who are the primary initial reporters, is especially important. The data also suggest that, when children self-report, they usually do so to a staff person charged with their care, indicating that diligent attention in staff training programs to the appropriate response of staff to children's reports is critical.

In mental retardation programs where many children are not able to communicate what may have happened to them, safeguards for accountable reporting are clearly even more difficult to ensure. In these settings, training for parents, clinical staff, and direct care staff in noting and evaluating unexplained injuries or fearful responses of children is especially important. Additionally, there is a need for habilitative programs for children with developmental disabilities to include an emphasis on self-protection and to identify individual staff to whom the children can tell "bad things" that may happen.

The extent to which the senior staff indicate to child care staff and the children served their concern and interest in complaints and allegations which are raised is a critical ingredient in an effective abuse and neglect reporting system.

The Commission's experience has also reinforced the importance of the attitude and behavior of supervisors and other clinical staff in promoting full reporting of allegations of abuse and neglect. The extent to which these senior staff indicate to child care staff and the children served their concern and interest in complaints and allegations which are raised is a critical ingredient in an effective abuse and neglect reporting system.

It is equally imperative that clinical and supervisory staff maintain a regular presence on living units when the children are present, and that they regularly review daily logs and communicate frequently with child care staff. This presence and regular communication has a myriad of benefits for a treatment program, one of which is that senior staff have a current and keen awareness of what actually is going on.

Recommendations:

- OMH and OMRDD should require all residential programs for children to develop and implement strategies which enhance children and family member reporting of harmful and untoward incidents which may constitute abuse or neglect and which ensure that front-line direct care and clinical staff respond to all such reports in a prompt, concerned, and effective manner.

One of the more distressing findings of this report is the large number of children who were cited in more t han one report of alleged child abuse or neglect in the first three years of CAPA's implementation.

- OMH and OMRDD should require all residential programs for children to develop explicit standards for regular clinical staff attendance on living units when the children are present, including during evening hours and weekends.

(3) Redoubling the Prevention Focus on "High Risk" Children

One of the more distressing findings of this report is the large number of children who were cited in more than one report of alleged child abuse or neglect in the first three years of CAPA's implementation. Even more troubling were the 32 children who surfaced in four or more reports during this period.

In an effort to arrange greater protection for these youngsters, the Commission recommends that the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities develop guidelines for their state-operated and -licensed children's residential programs to promote accountable follow-up and, where warranted, individualized protective services plans for all "repeat" children. The Commission has also decided to attend more closely to children who repeatedly surface in reports and to ensure timely notification of OMH and OMRDD of the vulnerability of these identified children.

In this effort, the Commission also recommends that individual facilities study their reports to determine if there are any trends in the characteristics of "repeat" alleged victims and the allegations in which these children are involved. The preliminary analysis done by the Commission suggests that there may be some common characteristics among the "repeat" children and the reports in which they are cited. Identifying these risk factors may add further to the ability of individual facilities to protect these "high risk" children.

Recommendations:

- OMH and OMRDD should require residential programs for children to develop and implement procedures which ensure the identification and special protection of children who are identified in repeated reports of child abuse or neglect to the State Register.

- OMH and OMRDD should assist residential programs for children in identifying significant trends associated with "repeat" alleged victims of child abuse and neglect and in developing and implementing appropriate systemic corrective actions to ensure greater protections for these children.

(4) Addressing High Risk Behaviors and Circumstances

The data clearly identify certain child and staff behaviors and certain circumstances frequently associated with allegations reported to the State Central Register. Many reports of physical abuse and inappropriate restraint or seclusion of children, for example, clearly emanated from specific crisis situations which child care staff failed to handle properly, often because they had not been properly trained or because clinical staff had failed to develop a practical individualized behavioral plan for attending to the child's aggressive or assaultive behavior.

Additionally, many of the reports of staff neglect contributing to child-to-child sexual activity in mental health residential programs appeared to derive from the program's failure to address the child's prior known history of familial sexual abuse and/or from lax supervisory practices which provided the children with opportunities for sexual activity. The Commission also came to understand that in at least several residential programs, inappropriate sexual activity among children was rooted in the lack of formal training for clinical staff in assessing or addressing these behaviors or the child's past sexual abuse history in therapy. In many programs, staff had also failed to articulate clearly acceptable standards for children's behavior.

Finally, the data reinforced previous Commission findings that the most vulnerable times for child abuse and neglect in mental health and mental retardation residential programs are during unstructured "free time," when professional staff are often not immediately available. While acknowledging that all children need some down time, the Commission believes that extended periods of "free time" during late afternoon and early evening hours are not helpful or constructive for children or child care staff and that this issue should be actively addressed by program directors.

While recruiting professional staff willing to work evenings and weekends is difficult, the variable success of programs in achieving this goal suggests that better performance is attainable by many programs.

Additionally, while the Commission has encountered a number of programs which have taken aggressive steps to ensure more ongoing professional staff presence on the living units when children are awake, many others have continued to allow most of their professional staff to keep work schedules which almost completely coincide with the child's school day and allow only minimal professional staff coverage during evenings and weekends when children spend most of their time in the facility. The tendency of many residential programs to locate clinical staff offices quite apart from the children's living areas also promotes the separation of these staff from the children and their daily activities.

While the Commission recognizes that recruiting professional staff willing to work evenings and weekends is difficult, the variable success of programs in achieving this goal suggests that better performance is attainable by many programs and that program directors, as well as OMH and OMRDD, should actively promote its achievement.

Recommendations:

- ❑ OMH and OMRDD should inform program directors of residential programs for children of the identified "risk factors" associated with many reports of alleged child abuse and neglect filed with the State Register and require that each program consider the relevance of these factors and, where applicable, develop systemic corrective action plans to address them.

(5) Accountability for Appropriate Corrective Action Recommendations

CAPA restricts authorization to the Commission and the Department of Social Services in making recommendations for corrective actions to "indicated" reports of institutional child abuse and neglect. As explained in this report, many "unfounded" reports also involve a confirmed harmful event to a child, staff misconduct, and/or significant program deficiencies which warrant correction. This limitation has had little impact on the Commission as its existing statute authorizes recommendations in any investigation of abuse or neglect, but it has limited the actions taken by the Department of Social Services.

Given the multiplicity of problems that may surface in the conduct of any investigation, the Commission strongly recommends that the investigatory agency be authorized to issue appropriate recommendations in all reports where the investigation reveals deficiencies or problems.

Given the multiplicity of problems that may surface in the conduct of any investigation, the Commission strongly recommends that the authority of the investigatory agency to issue appropriate recommendations be extended to all reports where the investigation reveals deficiencies or problems in the care, supervision, or treatment of children. Additionally, to ensure accountability, the Commission recommends that the respective state agency charged with licensing/certifying the residential program be responsible for monitoring its implementation of needed corrective actions.

Recommendations:

- OMH and OMRDD should develop procedures to ensure that residential programs for children responsibly address problems and deficiencies affecting the safety, well-being, and/or appropriate supervision of children identified in the course of Commission investigations of reports of child abuse and neglect as a condition for the Offices' continued certification of these programs.

* * *

A draft of this report was shared with senior staff of the OMRDD and OMH. Both agencies provided comments and suggestions to the draft, many of which have been incorporated in this final report. Written responses of the Commissioners of OMRDD and OMH to the draft report are included in Appendix D.

Appendix A

Statutory Definitions of Child Abuse and Neglect

Statutory Definitions of Child Abuse and Neglect

Abuse in Institutional Settings

An "abused child in residential care" means a child whose custodian (director, operator, employee or volunteer of a residential care facility or program):

(a) inflicts or allows to be inflicted upon such child physical injury by other than accidental means which causes or creates a substantial risk of death, serious protracted disfigurement, protracted impairment of physical or emotional health or protracted loss or impairment of the function of any organ;

(b) creates or allows to be created a substantial risk of physical injury to such child by other than accidental means which would be likely to cause death or serious or protracted disfigurement, protracted impairment of physical or emotional health, or protracted loss or impairment of the function of any organ; or

(c) commits, or allows to be committed, a sex offense against such child, as described in the penal law; allows, permits or encourages such child to engage in any act described in section 230.25, 230.30 or 230.32 of the penal law; commits any of the acts described in section 255.25 of the penal law; or allows such child to engage in acts or conduct described in article 263 of the penal law, provided, however, that (i) the corroboration requirements in the penal law and (ii) the age requirement for the application of article 263 of such law shall not apply to proceedings commenced pursuant to this title or Article 10 of the Family Court Act.

Abuse in Familial, Foster Care, and Day Care Settings

"Abused Child" mean a child less than 18 years of age whose parent or other person legally responsible for the child's care:

(i) inflicts or allows to be inflicted upon such child physical injury by other than accidental means which causes or creates a substantial risk of death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health, or protracted loss or impairment of the function of any bodily organ; or

(ii) creates or allows to be created a substantial risk of physical injury to such child by other than accidental means which would be likely to cause death or serious or protracted disfigurement, or protracted impairment of physical or emotional health, or protracted loss or impairment of the function of any bodily organ; or

(iii) commits or allows to be committed a sex offense against such child, as defined in the penal law; allows, permits or encourages such child to engage in any act described in sections 230.25, 230.30 and 230.32 of the penal law; commits any of the acts described in section 255.25 of the penal law; or allows such child to engage in acts or conduct described in article 263 of the penal law, provided, however, that (a) the corroboration requirements contained therein in the penal law and (b) the age requirement for the application of article 263 of such law shall not apply to proceedings under this article.

Neglect in Institutional Settings

A "neglected child in residential care" means a child whose custodian impairs, or places in imminent danger of becoming impaired, the child's physical, mental or emotional condition:

(a) by intentionally administering to the child any prescription drug other than in accordance with a physician's or physician's assistant's prescription;

(b) in accordance with the regulations of the State agency operating, certifying or supervising such facility or program, which shall be consistent with the child's age, condition, service and treatment needs, by:

(i) failing to adhere to standards for the provision of food, clothing, shelter, education, medical, dental, optometrical or surgical care, or for the use of isolation or restraint; or

(ii) failing to adhere to standards for the supervision of children by inflicting or allowing to be inflicted physical harm, or a substantial risk thereof; or

(c) by failing to conform to applicable State regulations for appropriate custodial conduct.

Maltreatment in Familial, Foster Care, and Day Care Settings

"Maltreated Child" means a child less than 18 years of age:

(i) whose physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of the child's parent or other person legally responsible for the child's care to exercise a minimum degree of care:

(a) in supplying the child with adequate food, clothing, shelter or education in accordance with the provisions of part one of article 65 of the education law, or medical, dental, optometrical or surgical care, though financially able to do so or offered financial or other reasonable means to do so; or

(b) in providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or a substantial risk thereof, including the infliction of excessive corporal punishment; or by misusing a drug or drugs; or by misusing alcoholic beverages to the extent that he loses self-control of his actions; or by any other acts of a similarly serious nature requiring the aid of the court; provided, however, that where the respondent is voluntarily and regularly participating in a rehabilitative program, evidence that the respondent has repeatedly misused a drug or drugs or alcoholic beverages to the extent that he loses self-control of his actions shall not establish that the child is a neglected child in the absence of evidence establishing that the child's physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as set forth in paragraph (i) of this subdivision; or

(ii) who has been abandoned, in accordance with the definition and other criteria set forth in subdivision five of section 384-b of the Social Services Law, by his parents or other person legally responsible for his care.

Appendix B

Office of Mental Health and Office of Mental Retardation and Developmental Disabilities Regulatory Definitions of Abuse and Neglect

I. NYS Office of Mental Health Regulatory Definitions of Abuse and Neglect

14 NYCRR 524

Client abuse means any of the following acts of an administrator, employee, consultant or volunteer which involves a client, of any age, who is the victim or target of:

(1) *physical abuse*, which means any nonaccidental contact with a client which causes or has the potential to cause physical pain or harm, including but not limited to hitting, kicking, slapping, shoving, punching or choking;

(2) *sexual abuse*, which means any sexual contact involving a client and an administrator, employee, consultant or volunteer; any sexual contact among nonconsenting clients which is allowed or encouraged by an administrator, employee, consultant or volunteer (for the purposes of this Part, a person less than 17 years of age is deemed incapable of consent);

(3) *psychological abuse*, which means any verbal or nonverbal action by an administrator, employee, consultant or volunteer which is intended to cause a client emotional distress, including but not limited to teasing, taunting, name calling or threats.

Neglect means any action or inaction of an administrator, employee, consultant or volunteer which impairs or places in imminent danger of becoming impaired, the physical, mental or emotional condition of a client.

II. NYS Office of Mental Retardation Regulatory Definitions of Abuse and Neglect

14 NYCRR 624

Abuse. The maltreatment or mishandling of a client which would endanger the physical or emotional well-being of the client through the action or inaction on the part of any individual, including an employee, volunteer, consultant, contractor, visitor, or other persons, whether or not the client is or appears to be injured or harmed. The failure to exercise one's duty to intercede in behalf of a client also constitutes abuse. All allegations (see glossary, section 624.20 of this Part) of client abuse are to be reported on a standardized form (see glossary) subject to approval by OMRDD; reviewed, investigated and reported to designated parties according to established procedures; reviewed by a standing committee; and acted upon in an appropriate manner by the program administrator to safeguard the well-being of clients and to bring the matter to closure. All allegations of client abuse must be immediately reported to OMRDD and followed up in writing on form OMR 147(A), Allegation of Client Abuse. Abuse is categorized as follows:

(1) *Physical abuse*. Physical contact which may include, but is not limited to, such obvious physical actions as hitting, slapping, pinching, kicking, hurling, strangling, shoving, or otherwise mishandling a client. Physical contact which is not necessary for the safety of the client and causes discomfort to the client may also be considered to be physical abuse, as may the handling of a client with more force than is reasonably necessary.

(2) *Sexual abuse*. Any sexual activity between employees, consultants, contractors or volunteers and clients. Any sexual activity between clients and others or among clients is considered to be sexual abuse, unless the involved client(s) is a consenting adult. Sexual abuse includes any touching or fondling of a client directly or through clothing for the arousing or gratifying of sexual desires. It also includes causing a client to touch another person for the purpose of arousing or gratifying personal sexual desires.

(3) *Psychological abuse*. The use of verbal or nonverbal expression in the presence of one or more clients that subjects the client(s) to ridicule, humiliation, scorn, contempt or dehumanization, or is otherwise denigrating or socially stigmatizing. In addition to language and/or gestures, the tone of voice, such as that used in screaming or shouting at or in the presence of clients, may, in certain circumstances, constitute psychological abuse.

(4) *Seclusion*. The placement of a client in a secured room or area from which he or she cannot leave at will is considered to be seclusion, not time-out (see glossary, section 624.20 of this Part). Seclusion is considered to be a form of client abuse and is, therefore, prohibited.

(5) *Unauthorized or inappropriate use of restraint*. The use of a device to restrain a client without the written, prior authorization of a physician; or the head of shift (see glossary, section 624.20 of this Part) if the physician cannot be present within 30 minutes. The intentional use of a medication to control a client's behavior that has not been prescribed by a physician for that purpose is considered to be unauthorized use of restraint. Inappropriate use of a restraint shall include, but not be limited to, the use of a device(s) or medication for the convenience of staff, as a substitute for programming, or for disciplinary (punishment) purposes.

(6) *The unauthorized or inappropriate use of aversive conditioning* (see glossary, section 624.20 of this part) The use of aversive conditioning without appropriate permissions is the unauthorized use of aversive conditioning. Inappropriate use of aversive conditioning shall include, but not be limited to, the use of the technique for the convenience of staff, as a substitute for programming, or for disciplinary (punishment) purposes.

(7) *The unauthorized or inappropriate use of time-out* (see glossary, section 624.20 of this Part). The use of time-out without appropriate permissions is the unauthorized use of time-out. Inappropriate use of time-out shall include, but not be limited to, the use of the technique for the convenience of staff, as a substitute for programming, or for disciplinary (punishment) purposes.

(8) *Violation of a client's civil rights*. Any action or inaction which deprives a client of the ability to exercise his or her legal rights, as articulated in State or Federal law.

(9) *Mistreatment*. The deliberate and willful determination on the part of a provider agency's administration or staff to follow treatment practices which are contraindicated by a client's individual program plan, which violate a client's human rights, or do not follow accepted treatment practices and standards in the field of developmental disabilities.

(10) *Neglect*. A condition of deprivation in which clients receive insufficient, inconsistent or inappropriate services, treatment or care to meet their needs; or failure to provide an appropriate and/or safe environment for clients. Failure to provide appropriate services, treatment or care to a client by gross error in judgment, inattention or ignoring may also be considered a form of neglect.

Appendix C

Child Abuse Reporting Rates

Child Abuse Reporting Rates

Program Type	Year 1[1] Children Served[2]	Year 1 Reports	Year 1 Reporting Rate[3]	Year 2 Children Served	Year 2 Reports	Year 2 Reporting Rate	Year 3 Children Served	Year 3 Reports	Year 3 Reporting Rate	3-Year Average Reporting Rate
MH Facilities										
CPC	1615	74	4.58	1768	94	5.32	1705	182	10.67	6.86
CYU	1347	31	2.30	1413	16	1.13	1456	110	7.55	3.66
RTF	326	23	7.06	469	34	7.25	460	54	11.74	8.68
28/31's[4]	5327	10	0.19	5261	22	0.42	N/A	31	–	0.31
Other[5]	238	1	0.42	50	1	2.00	57	4	7.02	3.15
MR Facilities										
DC	639	11	1.72	498	15	3.01	370	6	1.62	2.12
ICF	613	21	3.43	919	32	3.48	964	58	6.02	4.31
CR	89	1	1.12	155	1	0.65	153	3	1.96	1.24
PS/Other	250	5	2.00	243	2	0.82	255	8	3.14	1.99
TOTAL		177			217			456		

1 CAPA years run 10/86-9/87, 10/87-9/88, 10/88-9/89.
2 OMH #'s are for calendar years 1987, 1988, 1989.
3 Reporting rate is based on number of reports per 100 children served.
4 Only 5 Article 31 Hospitals have certified C & Y beds and admission data is incomplete for 1988, not available for 1989.
5 Children in non-certified beds.

Appendix D

Response of New York State Office of Mental Health and Office of Mental Retardation and Developmental Disabilities to Preliminary Draft Report

NEW YORK STATE
OFFICE OF MENTAL HEALTH
44 Holland Avenue, Albany, New York 12229

RICHARD C. SURLES, Ph.D., Commissioner

October 29, 1991

Mr. Clarence J. Sundram
Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, NY 12210

Dear Mr. Sundram:

I appreciate the opportunity to respond to the final draft of the Commission's review of three years of child abuse and neglect reports. Your willingness to listen to our feedback about the original draft and to incorporate many of our suggestions is also recognized and applauded.

We find this final draft, for the most part, a valid review and assessment of the data, and concur with many of the recommendations. OMH implemented an initiative in 1989 to enrich evening and weekend activities in our state-operated inpatient programs through both enhanced clinical presence and group work. Your current recommendation reinforces our commitment to continue this initiative. We also agree with your recommendation on safety priorities and continue to diligently follow-up with programs on ensuring the safety, well-being, and/or supervision of children after alleged incidents of abuse or neglect.

Additionally, we intend to strengthen our efforts to identify and review "repeater" and/or "high risk children" based on your findings and to continue to improve our training efforts in the area of child abuse reporting and follow-up, especially in OMH licensed programs.

After our initial review with the Commission staff of the original draft, we held further discussions at OMH. We would like to use this response as an opportunity to point out what we find is an unfortunate misrepresentation of the OMH system throughout the report and throughout the Child Abuse Prevention Act. OMH does not believe that we currently run "institutions". The word institution conjures up an image of large residential programs where custodial care is the priority and patients remain for long periods of time. Although this image may have accurately reflected our treatment centers many years ago, we are convinced that the terms "institution" and "institutional abuse" no longer represent OMH programs or alleged abuse in OMH programs.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

44 HOLLAND AVENUE • ALBANY • NEW YORK • 12229-0001

ELIN M. HOWE
Commissioner

THOMAS A. MAUL
Executive Deputy Commissioner

October 23, 1991

Mr. Clarence J. Sundram
Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, New York 12210-2895

Dear Chairman Sundram:

The Office of Mental Retardation and Developmental Disabilities (OMRDD) would like to reaffirm the positions stated in the July 19, 1991 letter. Essentially, we are encouraged by the progress made in curbing the incidence of child abuse and neglect in residential facilities.

To reiterate, OMRDD has been diligent and proactive with respect to the prevention of child abuse and maltreatment. We believe that central to the prevention strategy has been staff training and a highly sensitive regulatory threshold. The definition of abuse and maltreatment provided in 14 NYCRR, Part 624, has proven to be an exceptional measure of deterrence and prevention of systemic abuse and neglect. More, this definition provides a far more precise definition of abuse and maltreatment which serves as a "safety net" for our constituency. The report suggests that our Part 624 definition of abuse and maltreatment has lead to confusion and inappropriate reports. However, we remain unconvinced that the regulatory definition in Part 624 should be abandoned solely to eliminate the potential for staff confusion, as its elimination would not be in the best interest of our children.

The phenomena of "repeater" children is one which deserves closer scrutiny. To address the problem of "repeater" and/or high risk children in our facilities, we will work with the Commission to identify those children and to reevaluate their needs. It is our intention for these clinical and programmatic evaluations to provide a basis for the development of new individualized behavior and service plans to address and mitigate the problems. We will also implement a monitoring mechanism to ensure that other children who may have similar problems are readily identified by facility staff. In this effort we will enlist or involve the incident review committee, the program's QA staff, interdisciplinary teams and other staff as appropriate.

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Of high interest to OMRDD is the relationship between abuse and staff training and appropriate supervision during "high risk periods." For example, the report states that incidents of abuse are more likely to occur during "unstructured time" when "direct care staff" are left alone with the children. We would like to explore these relationships closer to attempt to ascertain to what degree they contribute to increase opportunities of incidents.

Prevention of abuse and maltreatment is a major focus of our training efforts along with pre-employee background screening. The report provides brief details on perpetrators, but a demographic and character profile of perpetrators would be useful. A profile of subjects of child abuse can help us strengthen and reinforce our staff screening methodology, and also make more acute supervisory vigilance. Formal training for clinical and managerial staff to become familiar with the conditions, the personalities, and other contributory factors that increase occurrences of abuse and neglect may be developed from the data on which your findings are based.

The report places a great deal of emphasis on training as a means to improve the reporting of child abuse allegations on the part of all employees. We concur with this basic approach. However, we propose to further explore different approaches to improve the quality of incident reports, to safeguard against non-reporting and to involve more varied individuals as reporters. In concert with training, we propose to enlist ombuds people, members of the boards of visitors, and self-advocates. These additional would-be reporters with their varied talents and insight, can help remediate the problems relating to underreporting and quality reporting, while providing additional non-staff safeguards to ensure the continued reliability of incident reporting.

We would like the Commission to join us in exploring strategies and approaches to further reduce incidents of child abuse. Our efforts will continue to emphasize prevention and avoidance. OMRDD remains aggressive to ensure that abuse will not disrupt or damage the lives of children with developmental disabilities.

Sincerely,

Elin M. Howe
Commissioner

EMH/TJC

The Commission on Quality of Care for the Mentally Disabled is an independent agency responsible for oversight in New York State's mental hygiene system. The Commission also investigates complaints and responds to requests concerning patient/resident care and treatment which cannot be resolved with mental hygiene facilities.

The Commission's statewide toll-free number is for calls from patients/residents of mental hygiene facilities and programs, their families, and other concerned advocates.

Toll-free Number: 1-800-624-4143 (Voice/TDD)